

TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.net

Cost: \$125
Turned in By: 4/28/2010

EVENT: Catalina Backpacking Trip, May 2010

DATE: Saturday, May 29, 2010 - Monday, May 31, 2010

LOCATION: Catalina Island
No Telephone

NEAREST HOSPITAL: Avalon Municipal Hospital Avalon (310) 510-0700

MEET AT: **St. Hedwig Parking Lot ON: Sat, 5/29/2010 at 5:00 AM** (5:15 departure from SH)
Need to be at San Pedro Terminal no later than 5:50 for 7:00 departure

RETURN TO: **St. Hedwig ON: Mon, 5/31/2010 at about 3:00-4:00 PM** (Check Boat Schedule)
Return boat is Catalina Express Leaving Two Harbors at 2:00pm

SCOUTMASTER / ADULT LEADER: **Audrey Hook / Joe Guadagno**

EMERGENCY CONTACT: **Mary Ellen Kane: (562) 430-1309**

PLEASE RETAIN TOP FOR YOUR RECORDS. SIGN AND RETURN THE FORM BELOW

PARENT / GUARDIAN PERMISSION FORM

I request that my son, _____, be permitted to go with Troop 671 on an outing/trip to Catalina Island Backpacking **on Saturday, May 29 – Monday, May 31, 2010**. He is in good physical condition. Should any illness or accident resulting in injury occur to him ON the outing/trip, **I WILL NOT** hold liable the Boy Scouts of America, the Orange County Council or Troop 671, its officers or leaders, for medical aid rendered and will reimburse the Orange County Council, BSA or Troop 671 for all medical or other expenses incurred in behalf of my son.

My son may receive necessary first aid. He may receive medical attention by a duly licensed physician or other authorized emergency medical technician. He may be admitted to a hospital in case of an emergency. This authorization is given in pursuant to section 25.8 of the civil code of the state of California and remains effective only for the events and dates listed above. In the event of an emergency, every effort will be made to contact the parents or legal guardian.

I am ABLE / UNABLE to participate for the ENTIRE EVENT / FOLLOWING DAY(S) _____.

SIGNATURE: _____ Date: ____/____/____

EMERGENCY CONTACT: _____ Phone #: _____ Relationship: _____

ALTERNATE Name: _____ HOME/CELL _____ HOME/CELL _____

PHONE #s

Name: _____ HOME/CELL _____ HOME/CELL _____

MEDICAL / HOSPITALIZATION INSURANCE INFORMATION

List of Medicines and attached directions for use: _____

List of Medicines my son is allergic to: _____

List of items my son is allergic to (bee stings, cats, dogs, hayfever, any foods, rashes): _____

Special instructions, conditions, etc: _____

Name of Insurance Company: _____ Policy Number: _____

Group No: _____ Name of Insured: _____

Insured Employer Info: _____ Phone: _____

My Son Physicians Name: _____ Phone: _____